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Long, Vicky

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Article

‘Heading up a blind alley’? Scottish psychiatric hospitals in the era of deinstitutionalization

Vicky Long
Glasgow Caledonian University

Corresponding author:
Vicky Long, Centre for the Social History of Health and Healthcare, Hamish Wood Building, Glasgow Caledonian University, Cowcaddens Road, Glasgow, G4 0BA, UK
Email: victoria.long@gcu.ac.uk

Abstract

This article examines Scottish provision of psychiatric care in the 1960s and 1970s. It demonstrates that institutional services did not rapidly disappear across the UK following the Ministry of Health's decision to shut down psychiatric hospitals in 1961, and highlights Scotland's distinctive trajectory. Furthermore, it contends that psychiatric hospitals developed new approaches to assist patients in this era, thereby contributing towards the transformation of post-war psychiatric practice. Connecting a discussion of policy with an analysis of provision, it examines the Department of Health for Scotland's cautious response to the Ministry's embrace of deinstitutionalization, before analysing Glasgow's psychiatric provision in the 1970s. At this point the city boasted virtually no community-based services, and relied heavily on its under-resourced and over-burdened hospitals. Closer analysis dispels any impression of stagnation, revealing how ideologies of deinstitutionalization transformed institutional care.

Keywords

Deinstitutionalization, Gartnavel Royal Hospital, long-stay patients, psychiatric hospitals, Scotland

Introduction

Recent studies of twentieth-century psychiatry observe that the narratives characterizing earlier histories of nineteenth-century mental healthcare fail to explain the complexities of both post-war psychiatry and proliferating extra-mural mental health services (Eghigian, 2011; Hess and Majerus, 2011; Turner et al., 2015). In particular, some have taken aim at earlier revisionist interpretations which depicted nineteenth-century asylums as instruments of social control: convenient repositories for the containment of inconvenient people during the era of industrialization which simultaneously acted as a vehicle for the ambitions of the nascent psychiatric profession. In this vein, a recent special issue of *History of Psychiatry* emphasized the 'impressive transformation of psychiatric treatment' which occurred in the twentieth century. Psychiatry, the guest editors Volker Hess and Benoît Majerus insisted, 'detached itself from the model of care in institutions' in the post-war era. In their view, those who ignore the truth of this observation and wilfully continued to focus on institutional care perpetuated an outmoded revisionist interpretation, thus 'heading up a blind alley' (Hess and Majerus, 2011: 140).

The present paper deliberately heads up this 'blind alley' by examining institutional provision of psychiatric care within Scotland in the 1960s and 1970s. In so doing, it demonstrates that psychiatry remained wedded to institutional care in Scotland until the final decade of the twentieth century, and it seeks to account for the distinctive trajectory of post-war Scottish mental healthcare. Beyond this, it aims to address an important issue which Hess and Majerus raise but then ignore: what became of elderly and chronically ill patients during this period of upheaval? I argue that we cannot abandon our study of psychiatric hospitals if we want to examine services for people who suffered from enduring mental health problems in the post-war era. Yet such an analysis does not simply extend existing narratives of institutional care into the late-twentieth century, for the picture which emerges from studying these hospitals in their final decades of operation is one of dynamic change, not stasis. Although hampered by archaic architecture and inadequate resources, hospital staff introduced new practices to address changing mental health policies and patients' needs, and in so doing contributed towards the transformation of psychiatry. We may yet find, as Eric Engstrom (2012: 490) has recently suggested, that psychiatric hospitals are an essential component of the histories of post-war mental healthcare, serving to illuminate 'historical contingency and local specificities', and thereby enabling us to arrive at a richer and more nuanced analysis than if focusing exclusively on community provision.

The paper connects a discussion of policy with an analysis of provision. It commences by studying how Ministry of Health staff responded to the needs of long-stay patients when formulating the policy of hospital closure in the early 1960s, before moving north of the border to examine the Scottish Home and Health Department's critical reaction to these policies. It then explores the challenges facing Glasgow's psychiatric services in the late-1970s, before outlining how Glasgow's Gartnavel Royal Hospital sought to transform the nature of care it provided under the auspices of psychiatric rehabilitation. Closer examination of the processes and practices of deinstitutionalization reveals that the post-war transformations of psychiatric services did not rapidly eradicate institutional care: rather, the ideologies of deinstitutionalization transformed the nature of institutional care and the role of ancillary and paramedical staff.

Psychiatric deinstitutionalization in England and Wales

The 1957 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (Percy Commission, 1957) was a crucial turning point in mental health policy in

the UK. It urged relocating mental healthcare from hospital to community settings and inspired the 1959 Mental Health Act, which empowered local authorities in England and Wales to establish community mental health provision. Throwing his weight behind the shift from hospital to community services in 1961, the Minister of Health Enoch Powell proposed cutting mental hospital bed provision by 50%, with an eye to eliminating mental hospitals entirely, claiming that such beds should in future be sited within general hospitals (Powell, 1961). Powell derived his figures from a statistical study of patient admissions and discharges between 1954 and 1959 undertaken by Dr Geoffrey Tooth, principal medical officer to the Ministry, and Eileen Brooke, a statistician employed by the General Register Office. Brooke and Tooth predicted that the long-stay population then resident in mental hospitals would disappear in 16 years if current trends continued, while acknowledging that a smaller cohort of new long-stay patients was likely to accumulate (Tooth and Brooke, 1961). A 1960 Ministry of Health paper accepted that discharge rates from long-stay wards were likely to drop 'as the hard core of organically deteriorated patients is reached', but argued that the disproportionately high mortality rate in mental hospitals would ensure that 'death alone … would eliminate these patients in about twenty-five years'.[1]

Working on these assumptions, Ministry of Health officials displayed little interest or enthusiasm for the challenges posed by long-stay psychiatric patients, even though three-quarters of the patients in mental hospitals in England and Wales in the early 1960s had been resident for more than two years (Wing, Bennett and Denham, 1964: 1). Speaking at a symposium which, in light of Ministry policy, was rather incongruously on the theme of 'The Future of the Mental Hospital', Tooth admitted that he was 'almost entirely without inspiration' as to how long-stay patients would be catered for in the future, beyond his view that 'the chronic and especially the brain-damaged psychotic who required no more than custodial care should not be mixed with those who were undergoing active treatment' (Anon., 1961). Tooth may have been uninspired, but psychiatrists working in mental hospitals were compelled to investigate how the government's new discharge targets could be met. David Clark, appointed Superintendent of Fulbourn Mental Hospital in 1953, recalled that the basic principle when he took up his post had been 'the traditional humane custodialism of British asylum management: look after patients kindly until they die, or perhaps, by chance, recover'. By the 1960s, he observed, 'we were just beginning to realize that the process of regaining social competence was far harder for long-term patients from mental hospitals than we had at first thought' (Clark, 1996: 218).

The therapeutic regimes of mental hospitals in the 1950s were transformed by the open doors movement (Clarke, 1993), the introduction of new drug therapies (Healy, 2002; Shorter, 1997) and the adoption of the therapeutic community approach (Mills and Harrison, 2007; Whiteley, 2004). These changes underpinned a rising number of discharges in the late-1950s, but to re-equip long-stay patients with the social skills necessary for independent living, psychiatrists turned to rehabilitation, a term hitherto associated with practices developed to assist injured and disabled ex-servicemen return to civilian life (Anderson, 2011). Foremost among the advocates of psychiatric rehabilitation in the post-war era was John Wing, director of the Medical Research Council's Social Psychiatry Research Unit between 1965 and 1989. Believing that patients' social needs could outweigh their medical needs, Wing sought to devise methods which would enable long-stay patients to leave the hospital and function in the community (Wing and Morris, 1981). Hospital rehabilitation programmes focused on occupying patients and providing them with the social and economic skills which they required for independent living, taking into consideration age, gender and the severity of impairment. Patients were encouraged to participate in recreational activities, and were trained in domestic skills such as cooking, laundry, shopping, budgeting and cleaning. Many hospitals also established industrial rehabilitation units, in which patients undertook industrial sub-contract work (Long, 2013).

Mental health policy in Scotland in the 1960s

At first glance, it appears that Scotland followed England's path towards psychiatric deinstitutionalization in the 1960s. In 1957 the Scottish Health Services Council appointed a committee to investigate whether the recommendations of the English Royal Commission on Mental Illness and Mental Deficiency should be applied in Scotland (Department of Health for Scotland, 1958, 1959). Subsequently, the 1960 Mental Health (Scotland) Act enacted provisions similar to those for England and Wales in the 1959 Mental Health Act. Both acts sought to enhance the liberty of psychiatric patients by making compulsory admission a last resort, promoting instead informal, voluntary admission to mental hospitals, and informal access to community services. In Scotland, the Secretary of State converted the powers of local health authorities to establish community provision into a duty to provide for the prevention, care and after-care of mental disorder, while the legislation also provided for the establishment of the Scottish Mental Welfare Commission, to oversee the liberty of psychiatric patients (Keane, 1987: 384).

Although the 1959 and 1960 Acts differed in some respects, there were enough similarities between the two to anticipate that the drive in England and Wales to close down psychiatric hospitals would be mirrored north of the border. Indeed, even before the Act was passed one Scottish Home and Health Department official, Mr Graham, anxiously wrote to his colleague Mr Skinner about the difficulties he foresaw in delivering the potential advances promised in the Bill. Mental hospitals, he feared, were ill-equipped to deliver their new role as little progress had been made in developing outpatient facilities and day hospitals. It was far from clear, in his view, whether hospital authorities or local authorities would organize the proposed development of community services, and in either case there was a significant shortfall of social workers to deliver such services. 'I am not sure that I have this problem in proper perspective, and I may be over-emphasizing either its urgency, or its scale,' he wrote, 'but I should have thought that it was likely to be one of the major health problems in the '60s and that the new legislation will give us an opportunity to set things moving.'[2] Certainly, little progress had been made in the development of community services in Scotland prior to the passing of the 1960 Act. While local health authority spending on services increased overall by 48% in Scotland in the decade between 1951–52 and 1961–62, spending by local health authorities on mental healthcare services was only £1000 more in 1961–62 than in 1951–52, which in light of inflation amounted to a 25% cut (Keane, 1987: 335). These services were confined to provision for people diagnosed as mentally defective, and did not include facilities for people suffering from mental illness (Martin, 1984: 67).

Other staff members at the Department were sceptical that the new legislation would deliver any radical changes to the system of psychiatric care then in place, citing the difficulty of predicting the pace at which inpatient numbers would decline. As Dr Craigie observed, this would surely depend in part on the extent to which local authorities developed alternative accommodation for discharged patients. Moreover, in his view, it was difficult to assess what impact recently introduced treatment methods would have on the number of patients.[3] This point was discussed at some length in a 1961 departmental memorandum, which argued that it was accordingly impossible to make long-term plans for mental health services because of the distinctive characteristics of mental illness:

> Because the causes of so many mental illnesses are unknown and because diagnoses are to some extent artificial and speculative, so treatment is largely empirical … the present successes resulting from drug treatment in mental illness may be transient and

> the patients who are at present responding so well to such treatment may ultimately relapse … if this happens, the readmission rate will increase … Alternatively, the exact opposite may happen … Even if the cause and cure of one major mental illness, schizophrenia, was discovered the whole future of mental hospitals, including their design, might be transformed.[4]

Lacking the conviction of their counterparts in London that psychiatric hospitals could be rapidly emptied of their patients, departmental officials did not enthusiastically embrace Powell's proposals for England. 'I understand … that there is some concern amongst Scottish psychiatric medical and nursing staffs of the effects on their future of recent English pronouncements on the future of mental hospitals', noted Mr Skinner in 1961.[5] However, he observed, there was no comparable evidence of a fall in mental hospital inpatients in Scotland.

In practice, Scottish mental health policy in the 1960s would deviate substantially from English policy, thereby supporting a contention that the National Health Service (NHS) in Scotland operated with a substantial degree of autonomy (Stewart, 2003). A departmental paper drawn up by Skinner highlighted the differences in psychiatric care between the two countries. One noticeable variation was the higher bed ratio per thousand of population: 4 in Scotland, versus 3.4 in England. The inpatient population peaked in England in 1955 and was followed by a 10% decline in the number of hospital inpatients in the following four years.[6] However, Scotland's inpatient peak of 20,925 occurred a year later (General Board of Control for Scotland, 1957: 6), and had been followed by only a 5% decline in the number of inpatients to 19,918 over the next four years (General Board of Control for Scotland, 1961: 6). This amounted to a 0.01% decline in the proportion of the overall population of Scotland which received inpatient care for mental illness, from 0.4%, to 0.39%.[7] A 1960 survey of accommodation in Scottish mental hospitals revealed that many remained overcrowded when assessed against the standards of the General Board of Control for Scotland. Dayroom accommodation was found to be particularly stretched, which may partly have reflected a growing emphasis on psychiatric rehabilitation: the physician superintendent at Bangour Hospital, where dayroom accommodation was calculated to be 40% overcrowded, observed that more patients were up and about than they used to be.[8]

Another significant difference in the policy of the two countries lay in the attitude towards psychiatric units sited in general hospitals. For Powell, these represented the future of

psychiatric inpatient care, and could in time replace the need for beds within psychiatric hospitals (Ministry of Health, 1962b: 8). Such units were operational in Scotland, but Skinner viewed them as an impediment to progress: an 'over-indulgence' which creamed off the more promising patients and swallowed up resources that should rightfully be channelled to mental hospitals. Skinner singled out the situation in Glasgow as one of particular concern.[9] A heated exchange of letters in the *Glasgow Herald* in 1961 suggested that the dual system of psychiatric care operating in the city had generated friction among doctors, with proponents of the units condemning the current 'archaic system' and expressing the view that Scotland was 'trailing behind' because psychiatrists working in mental hospitals were prioritizing 'their personal wish for increased power, increased salary or increased status'.[10]

Departmental officials believed that general hospitals lacked a number of resources specially designed to assist psychiatric patients, and favoured upgrading mental hospital care by using the small drop in inpatient numbers to relieve overcrowding and close down wards in old, obsolete buildings. Psychiatric units in general hospitals, they believed, should not be developed at the expense of existing mental hospitals, and efforts should be made to integrate the two forms of provision to stop a two-tier service developing. Yet significant disparities in the discharge rates of different mental hospitals suggested that levels of care and treatment varied between such hospitals, which also needed to be addressed if all patients were to receive the same standard of care. For example, while 77% of the patients resident at Gartnavel Royal Hospital in 1961 had been admitted that year, the comparable figure for Woodilee, another mental hospital serving the Glasgow region, was 41%.[11] These disparities probably stemmed from past factors. Historically, Gartnavel Royal had been the more prestigious hospital of the two, choosing to exile its pauper patients to purpose-built pauper lunatic asylums such as Woodilee in the late-nineteenth century. This policy was only reversed following the inauguration of the NHS, leaving a residuum of private patients in the hospital into the 1960s (Andrews, 1993). Furthermore, 74% of Gartnavel Royal's patients were resident on a voluntary as opposed to certified basis, whereas the comparable figure for Woodilee was only 40% (General Board of Control for Scotland, 1961: 17)

Stewart (2003) notes that Scotland's distinctive geography often served as grounds to diverge from English health policy, and this observation characterized mental health policy, for the Department argued that differences in the location and size of the existing mental hospital stocks of the two countries merited the adoption of different policies. England, claimed Skinner, was burdened with large, remote hospitals, while Scottish mental hospitals

were, in his view, generally conveniently located for the population. Skinner concluded that 'suitably sited mental hospitals will continue to play a major part in psychiatric care',[12] a view reiterated in the Department's 1962 hospital plan (Department of Health for Scotland, 1962: 38). The plan also deliberately omitted projected mental illness bed ratios for 1975 in its calculation of future bed requirements, noting 'no ratio has so far been established for mental beds' (p. 32).

The paper by Tooth and Brooke (1961) which shaped policy in England and Wales did not analyse Scottish data, so in 1966 the Department launched its own study to ascertain future provision for people suffering from mental illness in Scotland. The study, carried out by Elizabeth Warren for the Department's research and intelligence unit, aimed to review figures for admissions, discharges and overall inpatient numbers since 1963. It also sought to identify the number of psychiatric beds in different types of hospitals, and the extent of community services. Because the budget for mental health services was not ring-fenced, individual regional hospital boards determined how much of their overall budget should be expended on such provision. This factor alone led to variations in the nature of the services provided, but as Warren began to gather information from the hospital boards, others emerged. Some hospital boards attributed the dearth of community services – for example, only three local authority hostels were operating in Scotland by 1966 – to geography. Hospital boards, particularly those covering large and sparsely populated areas, argued that psychiatrists were unable to supervise patients in the community due to the distances involved, and therefore elected to keep patients in hospital until they could be discharged directly to their homes.[13] However, this did not account for the lack of extramural facilities in densely populated areas, such as Glasgow. Similar considerations affected the composition of hospitals' inpatient populations. Sunnyside Royal Hospital, located near Montrose, used to have a wide catchment area which encompassed Aberdeen, Orkney, Shetland and Fife. Consequently, by 1966 it had a residuum of older patients with no family ties who would be particularly difficult to discharge.[14] Perhaps unsurprisingly in light of the above, Warren's study revealed considerable regional variation in rates of hospitalization across Scotland, a finding which poured doubt on the idea that an ideal national bed ratio could be arrived at for Scotland, as it had been for England and Wales in Brooke and Tooth's study. Indeed, considerable variation could exist even within the area served by a single hospital board. The overall ratio of psychiatric beds within the Western Regional Hospital Board, for example, stood at 3.89 per 1000 of population, but ranged from 2.2 psychiatric beds per 1000 in

Ayrshire to 8 in Argyllshire and Dumfriesshire. Most of these beds accommodated long-stay patients: projecting a bed ratio of 3.10 for the period spanning 1965 to the 1980s, the report anticipated that 2.5 of those beds would serve long-stay patients, with only 0.26 and 0.34 set aside for short-stay and medium-stay patients respectively. Most mental hospitals, the Board anticipated, 'will continue to function for many years'.[15]

Warren's research revealed that little progress had been made in developing local authority services to support community care. Surveying the number of local authority personnel employed in mental health work, Warren identified considerable variation across Scotland: while 43% of the local authority staff employed in the North East region were involved in mental health work, for example, only 3.75% of the staff in the Northern region were similarly employed, equating to 1.5 posts, or 0.1 staff members per 1000 population. Overall, the picture in Scotland compared unfavourably to the situation in England and Wales, which had a ratio of 3.51 staff per 1000 of population, versus 1.34 in Scotland. Observing that 41% of the local authority staff employed in mental health work in some capacity were unqualified, Warren concluded that the expansion of community care would 'necessitate a considerable increase in the number of qualified full-time mental health staff'.[16] No comparable figures were given for England and Wales, but social work qualifications were not viewed as an essential prerequisite for local authority mental health work here in the 1940s and 1950s, and training only began to be taken more seriously in the 1960s (Rolph, Atkinson and Walmsley, 2003: 350–2).

The study prepared by Warren for the Scottish Home and Health Department asserted that Brooke and Tooth's recommendations could not be applied to Scotland. In part, this conclusion was premised upon distinctive characteristics of Scottish psychiatric care, which generated very different statistics. While the number of psychiatric inpatients in England and Wales fell by 14% between 1961 and 1968 from 135,860 to 116,406 (Department of Health and Social Security, 1969: 208; Ministry of Health, 1962a: 153), the pace of decline in Scotland slowed over the same period, falling by only 3% from 19,672 to 19,021 (General Board of Control for Scotland, 1962: 5; Scottish Home and Health Department, 1969: 85). Similarly, discharges from mental hospitals in Scotland between 1961 and 1965 had only risen by 4%, whereas the comparable figure for England and Wales was 14%.[17] However, the study also rejected Brooke and Tooth's prediction that the inpatient rate would decline arithmetically through discharges and death, siding with other researchers who argued figures throughout the UK for discharge and death rates suggested a geometric progression pattern,

with declines remaining constant as a proportion of the inpatient population left resident in a given year (Lindsay, 1962).[18] These calculations projected a much slower fall in the inpatient population. Finally, Warren's study disputed the underlying approach and assumptions of Brooke and Tooth's paper for, as one departmental paper explained, it challenged:

> the validity of any method of forecasting *needs* for beds based upon current statistics of bed *use* … if a reduction in the number of beds was made, based upon a statistical projection then this prediction would be a self-fulfilling one because no more patients could be accommodated than there were beds in which to treat them.[19]

Departmental staff argued that it would be more valuable to make policy decisions and then model the likely impact on bed needs, rather than base policy decisions about future needs on statistics which reflected current trends. The Department viewed Warren's report as a useful bulwark against the potential threat of pressure from the Treasury to adopt English bed ratios when planning Scottish services, reflecting the ongoing need to negotiate the fiscal implications of health policies with the Treasury (Stewart, 2003: 406). However, the Department elected not to disseminate the report widely due to its criticism of Brooke and Tooth's projections and, by implication, English mental health policy.

Psychiatric services in 1970s Glasgow

Analysis of psychiatric services provided by the Greater Glasgow Health Board in the late 1970s suggests that psychiatric provision had stagnated as a consequence of the Department's refusal to advocate hospital closures and the failure of regional hospital boards and local authority social work departments to prioritize mental health services. Glasgow's psychiatric hospitals – Gartloch, Gartnavel, Woodilee, Leverndale – continued to dominate service provision, offering just under 4000 beds. These hospitals had all been constructed in the nineteenth century, and by 1978 51% of their beds were filled by patients aged 65 and over, a figure predicted to rise in line with the growing percentage of Glasgow's population aged over 70. In a 1978 report, the psychiatric sub-committee of the Greater Glasgow area medical committee expressed fears that the city's psychiatric hospitals would become ghettos of psychogeriatric and long-stay patients, unable to accommodate acute cases of mental disorder or recruit adequate medical and paramedical personnel. Many short-stay patients were channelled to the psychiatric units sited in the city's other hospitals which provided a further

370 beds, fuelling long-standing divisions between the psychiatrists staffing these units and those in charge of the psychiatric hospitals.[20]

The sub-committee blamed the 'almost total non-fulfilment of social after-care policies' for the reliance upon the city's aging psychiatric hospitals. Glasgow, 'with its high loading of urban deprivation problems,' was 'sadly lacking appropriate environmental support systems' for discharged psychiatric patients. In the sub-committee's view, the fault lay with Glasgow's social work department. The 1960 Mental Health (Scotland) Act had empowered local authority social work departments to provide community-based services such as hostels, sheltered housing or sheltered workshops. However, Glasgow's social work department had failed to provide any of these services. As one social worker informed the psychiatric sub-committee, health had to compete with other branches of social work for local authority funds, and was assigned a relatively low priority.[21] Even if the department had a change of heart, it may have struggled to employ sufficient personnel to operate services given the demise of specialized training courses in psychiatric social work and the declining number of social workers employed in psychiatric services. The reorganization of the NHS in 1974, which had divided local authority social services and health services, impeded collaborative efforts to provide community-based services for discharged patients. Nor did it help that the boundaries of the local authority social work services differed from the boundaries of the district health services, frustrating efforts to coordinate local provision. These difficulties were replicated across Scotland. Indeed, while English community provision in the 1980s were widely acknowledged to be inadequate to support the number of people being discharged from psychiatric hospitals, it nevertheless provided between seven and eight times the level of day-care places available in Scotland (Martin, 1984: 71). As late as 1994, the Scottish Association for Mental Health (SAMH) suggested that social work departments only expended between 1% and 3% of their budget on mental health (Scottish Affairs Committee, 1995: v). The psychiatric sub-committee argued that the establishment of day hospitals catering for functional mental illnesses and psychogeriatric patients should be a priority, and suggested that the health board and the local authority should jointly fund homes to cater for psychogeriatric patients. Staffing new services nonetheless remained a concern due to shortages of allied professional staff: 'To appoint a consultant without supporting medical staff, nursing staff, occupational therapists, clinical psychologists, social workers and secretaries is almost useless', the committee concluded.[22]

At first glance, psychiatric provision in Glasgow in the 1970s appeared to have changed little over the previous 50 years. Community provision was virtually non-existent, and institutional care predominated. Yet, within the city's psychiatric hospitals we can detect changes in the nature of the inpatient population, the therapeutic activities undertaken and connections with external groups. Take Gartnavel Royal Hospital, for example, where the changing composition of the hospital's patients was reflected in its wards; by 1979, 11 of its wards catered for psychogeriatric patients, three catered for a combination of psychogeriatric and long-stay patients and five catered for long-stay patients. A further ward was set aside for efforts to modify patients' behaviour via the use of a token system, through which tokens, exchangeable for goods, were awarded for desirable behaviour, and withdrawn for undesirable behaviour. The Hospital only designated three wards for acute patients, and one ward for adolescent patients. Accordingly, the Hospital's staff attempted to tailor services within the hospital to meet the needs of the majority of its patients. Thus, one of the few new building projects on the Hospital site in the 1970s was McNiven House, a psychogeriatric unit, although the opening of this unit was delayed due to the difficulty of recruiting nurses. Gartnavel had pioneered the use of occupational therapy for mental illness in the 1920s (Paterson, 2008); by the 1970s occupational therapy was viewed as a key element of the hospital's rehabilitation programme and Gartnavel employed 11 occupational therapists and nine occupational therapy aides in 1976. These staff members sought to occupy patients through the use of sewing machines and typewriters, and in the Hospital's woodwork and metalwork workshops. They prepared long-stay patients for discharge by training them in domestic skills, and provided tailored services for psychogeriatric patients on the wards. However, the Hospital struggled to attract and retain occupational therapists. It also struggled to recruit social workers, which was particularly unfortunate given the inadequacies of local authority social work provision. Of the 7.5 social work posts in the hospital in 1975, three were vacant – something blamed on disparities in salaries and promotion opportunities in different sectors generated by the Social Work (Scotland) Act of 1975, which deterred applicants from work in hospitals. Gartnavel's staff and patients also had to contend with defective facilities. Throughout the Hospital, redecoration was rarely undertaken and kitchen and toilet facilities were outdated. Gartnavel's main occupational therapy building was deficient in many respects – the roof leaked, the toilet leaked, there was no hot water and the asbestos ceiling was cracked. In a hospital catering for a large number of elderly and frail patients, the absence of adjustable height beds was far from ideal.[23]

Hospitals sought to coordinate their own programme of activities with extramural services which could help patients on their discharge. For example, Gartnavel employed a coordinator of volunteer services sporadically throughout the 1970s and established a liaison committee with representatives from the Hospital's medical staff and the local authority social work department. These attempts to connect services are most apparent when considering patients' occupation within the hospital and efforts to help them secure employment on discharge by linking to services operated by the Department for Employment. Thus, the local disablement resettlement officer was a member of Gartnavel's rehabilitation committee, updating Hospital personnel on the employment prospects facing discharged patients.[24] He also served as a liaison point between the Hospital's industrial therapy unit and Department for Employment services for disabled people. Established under the auspices of the 1944 Disabled Persons (Employment) Act, this provision – operated by the government-subsidized company, Remploy – comprised of industrial rehabilitation units, which sought to restore the working capacity of disabled people, and sheltered employment for individuals deemed to be too disabled to work in open employment. Such initiatives, though, frequently fell victim to adverse economic circumstances. Reliant on two main providers for its industrial sub-contracts, Gartnavel did not have enough work available to employ all the patients reckoned to benefit from industrial therapy, and could not secure skilled work. When one of the two main subcontracts was terminated in 1976, 60% of the patients in the Hospital's industrial therapy unit were made redundant.[25] As regards extramural provision, the local authority had not provided any sheltered workshops, while the local industrial rehabilitation unit was often full. Moreover, the Department wanted to demonstrate that its facilities functioned on a value-for-money basis, and cautioned its industrial rehabilitation units against accepting too many former psychiatric patients, Department staff believing that they would be difficult to place into employment (Long, 2013). For similar reasons, fewer than 8% of Remploy's workforce in 1960 had a mental disorder or disability. When unemployment levels in the region rose, employment prospects for the Hospital's patients on discharge plummeted further. In 1976 one member of the rehabilitation committee damningly observed that 'rehabilitation as such barely existed in view of the virtual impossibility of patients obtaining outside employment',[26] while a year later the standing agenda item 'employment' was tellingly re-designated 'unemployment'.[27]

Studying the operation of Gartnavel Royal Hospital in the 1970s dispels the impression of institutional stagnation. While the range of institutions which comprised

Glasgow's psychiatric services had remained constant, the nature of these institutions changed in response to the ethos of deinstitutionalization and the needs of long-stay and aging patients. Accordingly, hospitals placed greater emphasis on patients' social and economic skills, forging links with extramural services which could address these needs. However, this analysis also reveals how fragile were the relationships between intra- and extramural facilities, and how vulnerable they were to adverse economic circumstances.

Conclusion

By delving into the policy and practice of psychiatric deinstitutionalization at a national and regional level, this article demonstrates the distinctive trajectory of deinstitutionalization in Scotland. Admittedly, Scottish and English psychiatric practice shared a number of common features in this era. English developments in the late-1950s and early-1960s formed the impetus behind subsequent developments in Scotland, and the 1960 Mental Health (Scotland) Act enshrined the principle of extramural care. Nevertheless, officials at the Department of Health for Scotland treated the developing English policies of psychiatric deinstitutionalization with a degree of scepticism. Rather than accepting the findings of Tooth and Brooke's 1961 study of inpatient trends in English mental hospitals, the Department commissioned its own study. The striking disparities revealed across Scotland in terms of rates of inpatient care, discharge rates and local authority services demonstrate the ongoing need to examine the geographies of mental healthcare as the ideologies and processes of deinstitutionalization gradually unfolded (Philo and Pickstone, 2009; Wolch and Philo, 2000). Pointing to the higher rate of hospitalization in Scotland, departmental officials argued that most Scottish psychiatric hospitals were conveniently sited for the populations they served, and envisaged that they would continue to function into the foreseeable future.

On one level this scepticism was not misplaced, for the pace of deinstitutionalization in England and Wales proved to be far slower than Powell had predicted. However, across the UK the longevity of the old psychiatric hospitals was due in no small measure to the failure of the government to establish community services to replace hospital care. This may have been intentional, for if Powell was motivated by a desire to save money by cutting hospital beds, there would have been little incentive to invest in extramural services. Sounding a warning note following Powell's announcement of the intended closure of psychiatric hospitals, Richard Titmuss (1961: 356) observed that local authority expenditure to deal with fowl pest currently outweighed expenditure on mental health and mental deficiency services. His plea

for ring-fenced funding to develop community services fell on deaf ears. Regional health authorities in England only began to formulate concrete plans to close psychiatric hospitals in the mid-1980s. Therefore, while the post-war era can be characterized as one which saw a shift away from institutional care towards community services, as Hess and Majerus contend, this shift occurred in a slow, uneven and piecemeal fashion. Progress towards deinstitutionalization was even slower in Scotland, where the Department's insistence that Scottish psychiatric hospitals would continue to function for many years was a self-fulfilling prophecy. This policy may well have reflected Scotland's greater emphasis on supporting hospital medicine, at the expense of other medical services (Stewart, 2003). In his analysis of mental healthcare in England and Scotland in the early 1980s, F.M. Martin concluded that, while England had outlined a policy of community care but only partially delivered it, the Department of Home and Health in Scotland had exhibited an 'excess of complacency', and consequently 'nothing has been promised and virtually nothing achieved' (Martin, 1984: 72–3). While the number of psychiatric inpatients in England and Wales fell by more than 50% in the 25 years following Powell's decision incrementally to shut down mental hospitals (Jones, 1993: 187, 243), the decline in Scotland over the same period was only 30% (General Board of Control for Scotland, 1962: 5; Information Services Division, 2015).

Proposals to close Scottish psychiatric hospitals began to be developed in the 1990s (Scottish Affairs Committee, 1995: vi), while Glasgow only embraced the policy of deinstitutionalization in the early-1990s when an assessment undertaken by the Greater Glasgow Health Board concluded that the city's mental health service was more likely to 'treat people in hospital and keep people in hospital' than anywhere else in Scotland, or Britain (Webster, 1994: 60). Subsequently, the Board and the Greater Glasgow Community and Mental Health Services NHS Trust promoted a:

> shift in emphasis from a poorly resourced community service being a rather patchy outreach of a huge psychiatric institutional service to a system in which the robust, properly resourced community services become the focus of the service with access to a small number of inpatient beds when required. (Davison, 1994: 53)

The Greater Glasgow Mental Health Strategy implemented joint planning and commissioning of health and social care to aid the shift from hospital to community services, with bridging funds to establish multidisciplinary community mental health teams across the city in advance

of the closure of Gartloch and Woodilee psychiatric hospitals (Davison, 1994). The Trust planned to streamline its personnel, acknowledging that voluntary and private providers would increasingly play a role in delivering community services. The challenge, however, lay in coordinating the establishment of community services and the closure of hospital facilities. Tim Davison, chief executive of the Trust between 1994 and 1999, feared moving too slowly and leaving resources tied up in declining institutional services, rather than investing in an effective community infrastructure, while SAMH complained that the hospital closure programme in Glasgow outpaced the provision of community structures (Scottish Affairs Committee, 1995: x).

The Department of Health for Scotland may well have been heading up a 'blind alley' in its refusal to initiate a programme for the development of community services until the 1990s, but our understanding of post-war mental health services in Scotland would be impoverished if we elected to overlook psychiatric hospitals in this era, for the survival of Scottish psychiatric hospitals into the late-twentieth century did not equate to institutional inertia. Instead, the slight drop in inpatient numbers in the 1960s served as an opportunity to improve hospital conditions, and the ethos of deinstitutionalization permeated the walls of psychiatric hospitals, radically altering the composition of the inpatient population: transforming the use of hospital space; encouraging hospitals to form stronger links with external bodies; and imbuing the roles of social workers and occupational therapists with a new significance as hospitals increasingly sought to rehabilitate long-stay patients. We could even argue that psychiatric deinstitutionalization paradoxically reinvigorated psychiatric hospitals, at least in the short term. Yet, it is apparent when we examine the operation of Glasgow's psychiatric hospitals in the late-1970s that this ethos was undermined by inadequate resources, for many were under-staffed, overstretched and struggling to cater for an increasingly ageing patient population with complex physical needs. This issue disproportionately affected Scotland, as England saw a greater development of local authority provision and private nursing homes for people suffering from senile dementia (Scottish Affairs Committee, 1995: v).

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Notes

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[4] Memorandum, 'Design of mental hospitals', 1961, HH59/166 (NRS).

[5] Note from Mr Skinner to Mr Graham, cc to Mr Hughes, Dr Craigie, Dr Smith and Miss Cox, 12 Apr. 1961, HH59/166 (NRS).

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[7] Percentages calculated from General Board of Control for Scotland figures above, which exclude cases under care in private dwellings and the State Mental Hospital / Criminal Lunatic Department, combined with table, 'Mid-year population estimates: Scotland, all ages by sex: 1855 to 2015':accessed (06 June 2016) at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/population-estimates-time-series-data.

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